

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2867

FILED FEB 4 1942

Registration District No. 347

Primary Registration District No. 3079

Registrar's No. 29

1. PLACE OF DEATH:

(a) County. Marion
 (b) City or town. Hannibal, Mo.
 (If outside city or town limits, write "RURAL", and name of township)
 (c) Name of hospital or institution: Levering Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution. 4 days
 (Specify whether
 In this community. 35 years
 years, months or days)

3. (a) PRINT
FULL NAMEIda Belle Suhler

3. (b) If veteran,

name war. —

3. (c) Social Security,

No. —

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced, widowed
 6. (b) Name of husband or wife Albert Suhler 6. (c) Age of husband or wife if alive — years
 7. Birth date of deceased November 2, 1872
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 2 22 — hr. — min.

9. Birthplace Barrington, Illinois
 (City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business

12. Name Jahn Jahnke
 13. Birthplace Germany
 (City, town, or county) (State or foreign country)
 14. Maiden name Sophia Emma
 15. Birthplace Germany
 (City, town, or county) (State or foreign country)

16. (a) Informant Miss Juanita Suhler
 (b) Address Hannibal, Mo.

17. (a) Burial (b) Date thereof Jan. 26, 1942
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Strand View Burial Camp

18. (a) Signature of funeral director Ray C. Schupf
 (b) Address 1000 Broadway, Hannibal, Mo.

19. (a) Jan 29 '42 (b) —
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion
 (c) City or town Hannibal
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1306 A Market St.
 (If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country —

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 24
 year 1942 hour 12 minute 45 P.M.

21. I hereby certify that I attended the deceased from Jan. 20 1942 to Jan. 24 1942
 that I last saw him alive on Jan. 24 1942
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy Duration 3 days
 Due to arteriosclerosis

Due to —
 Other conditions —
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations 430

Of autopsy —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) —
 (b) Date of occurrence —
 (c) Where did injury occur? — (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? —

While at work? — (Specify type of place) (e) Means of injury —

23. Signature Fredrick B. Spencer (M. D. or other) MD
 Address 2240 Hope Ave Date signed 1-28-42

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.
working under my personal supervision.

Signed Roy O. Schwartz
Licensed Embalmer No. 1765

P. O. Address 1700 Brady, Hannibal, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **2869**

Registration District No. **547**

Primary Registration District No. **3029**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Marion**
(b) City or town **Hannibal**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME

Ida B. Suhler

3. (b) If veteran,
name war _____

3. (c) Social Security
No. _____

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married,
divorced **W**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased **Nov 2 1873**
(Month) (Day) (Year)

8. AGE: Years **69** Months **3** Days **23** If less than one day _____ min.
9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____
19. **Jan 29 1942** (Date received local registrar) (b) **Robt W. Connor** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** Day **28** Year **1942** Hour _____ Minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

